FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041186

Facility Name: Tri-State Nsg & Rehab Ctr

Address: 2500 W. 175Th Street (Number) Lansing (City) 60438 (Zip Code)

County: Cook

Telephone Number: (708) 474-7330 **Fax #** (708) 474-7391

IDPA ID Number: 364034144001

Date of Initial License for Current Owners: 09/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,146	147	4,258	11,551	8
9	SNF/PED					9
10	ICF	9,869	7,212		17,081	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,015	7,359	4,258	28,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.39%

D. How many bed-hold days during this year were paid by Public Aid? 215 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 4,215

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	176,165	14,228	9,589	199,982		199,982	(3,871)	196,111			1
2	Food Purchase		112,245		112,245	(4,526)	107,719	957	108,676			2
3	Housekeeping	87,484	20,470		107,954		107,954	(2,153)	105,801			3
4	Laundry	67,757	10,513		78,270		78,270	(12)	78,258			4
5	Heat and Other Utilities			80,331	80,331		80,331	750	81,081			5
6	Maintenance	35,471		74,300	109,771		109,771	2,694	112,465			6
7	Other (specify):*							3,984	3,984			7
8	**TOTAL General Services**	366,877	157,456	164,220	688,553	(4,526)	684,027	2,348	686,375			8
	B. Health Care and Programs											
9	Medical Director			7,375	7,375		7,375		7,375			9
10	Nursing and Medical Records	1,206,063	22,689	5,824	1,234,576		1,234,576	3,772	1,238,348			10
10a	Therapy	112,386	3,698	2,259	118,343		118,343	254	118,597			10a
11	Activities	70,884	7,432	991	79,307		79,307	14	79,321			11
12	Social Services	62,471		2,558	65,029		65,029	77	65,106			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							1,137	1,137			15
16	**TOTAL Health Care and Programs**	1,451,804	33,819	19,007	1,504,630		1,504,630	5,254	1,509,884			16
	C. General Administration											
17	Administrative			119,658	119,658		119,658	5,584	125,242			17
18	Directors Fees											18
19	Professional Services			200,589	200,589	(10,500)	190,089	(130,776)	59,313			19
20	Dues, Fees, Subscriptions & Promotions			20,373	20,373		20,373	(12,871)	7,502			20
21	Clerical & General Office Expenses	57,300	8,755	52,575	118,630		118,630	37,451	156,081			21
22	Employee Benefits & Payroll Taxes			253,018	253,018	4,526	257,544	(17,579)	239,965			22
23	Inservice Training & Education			105	105		105		105			23
24	Travel and Seminar			540	540		540	551	1,091			24
25	Other Admin. Staff Transportation			780	780		780		780			25
26	Insurance-Prop.Liab.Malpractice			79,614	79,614		79,614	620	80,234			26
27	Other (specify):*							17,801	17,801			27
28	**TOTAL General Administration**	57,300	8,755	727,252	793,307	(5,974)	787,333	(99,219)	688,114			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,875,981	200,030	910,479	2,986,490	(10,500)	2,975,990	(91,617)	2,884,373			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr #0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			42,810	42,810		42,810	150,594	193,404			30
31	Amortization of Pre-Op. & Org.							7,803	7,803			31
32	Interest			21,962	21,962		21,962	157,015	178,977			32
33	Real Estate Taxes			124,721	124,721	10,500	135,221	1,114	136,335			33
34	Rent-Facility & Grounds			337,260	337,260		337,260	(335,416)	1,844			34
35	Rent-Equipment & Vehicles			5,212	5,212		5,212	909	6,121			35
36	Other (specify):*											36
37	**TOTAL Ownership**			531,965	531,965	10,500	542,465	(17,981)	524,484			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,798	211,874	330,672		330,672	(3,501)	327,171			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		118,798	257,864	376,662		376,662	(3,501)	373,161			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,875,981	318,828	1,700,308	3,895,117		3,895,117	(113,098)	3,782,019			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	70,254	30		9
10	Interest and Other Investment Income	(73,143)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(284)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	21		24
25	Fund Raising, Advertising and Promotional	(4,719)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,061)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (36,953)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(76,145)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (76,145)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (113,098)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Tri-State Nsg & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collection Expense	$ (67)	21	1
2	Bank Charges	(484)	21	2
3	Theft Loss	(735)	21	3
4	Bank Charges (Building Co)	(45)	21	4
5	Land Trust Fee (Building Co)	(405)	21	5
6	IL Council on LTC - COPE Dues	(1,068)	20	6
7	Assisted Living Parcel Real Estate Taxes	(2,257)	33	7
8				8
9				9
10				10
11				11
12				12
13				13
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97				97
98				98
99				99
100				100
101	**Total**	(5,061)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			25		(1,429)	(1,625)		(842)				(3,871)	1
2	Food Purchase	(284)		(44)			1,285						957	2
3	Housekeeping					470			(2,623)				(2,153)	3
4	Laundry								(12)				(12)	4
5	Heat and Other Utilities			750									750	5
6	Maintenance			783	272	1,721	4		(86)				2,694	6
7	Other (specify):*				3,412	475	97						3,984	7
8	**TOTAL General Services**	(284)		1,514	3,684	1,237	(239)		(3,564)				2,348	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			99	5	5,435			(1,767)				3,772	10
10a	Therapy					254							254	10a
11	Activities			14									14	11
12	Social Services				1	76							77	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				436	701							1,137	15
16	**TOTAL Health Care and Programs**			113	442	6,466			(1,767)				5,254	16
	C. General Administration													
17	Administrative				47	5,468	69						5,584	17
18	Directors Fees													18
19	Professional Services			(130,799)			23						(130,776)	19
20	Fees, Subscriptions & Promotions	(5,787)		(7,090)			6						(12,871)	20
21	Clerical & General Office Expenses	(25,736)	450	8,341		54,248	148						37,451	21
22	Employee Benefits & Payroll Taxes				(17,155)			(216)	(208)				(17,579)	22
23	Inservice Training & Education													23
24	Travel and Seminar			361			190						551	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			620									620	26
27	Other (specify):*				10,423	7,378							17,801	27
28	**TOTAL General Administration**	(31,523)	450	(128,567)	(6,685)	67,094	436	(216)	(208)				(99,219)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,808)	450	(126,940)	(2,559)	74,797	197	(216)	(5,538)				(91,617)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	70,254	76,346	3,994									150,594	30
31	Amortization of Pre-Op. & Org.		7,803										7,803	31
32	Interest	(73,143)	222,295	7,861			2						157,015	32
33	Real Estate Taxes	(2,257)	2,257	1,114									1,114	33
34	Rent-Facility & Grounds		(337,260)	1,844									(335,416)	34
35	Rent-Equipment & Vehicles			872			37						909	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(5,146)	(28,559)	15,685			39						(17,981)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,594)		(1,907)				(3,501)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(1,594)		(1,907)				(3,501)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(36,953)	(28,109)	(111,255)	(2,559)	74,797	(1,358)	(216)	(7,445)				(113,098)	45

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Lansing Healthcare Properties		Building Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 337,260	Lansing Healthcare Properties	100.00%	$	$ (337,260)	1
2	V	21	Bank Service Charges		Lansing Healthcare Properties	100.00%	45	45	2
3	V	21	Land Trust Fee		Lansing Healthcare Properties	100.00%	405	405	3
4	V	30	Depreciation Expense		Lansing Healthcare Properties	100.00%	76,346	76,346	4
5	V	31	Amortization Expense		Lansing Healthcare Properties	100.00%	7,803	7,803	5
6	V	33	RE Tax - Asst Living Parcel		Lansing Healthcare Properties	100.00%	2,257	2,257	6
7	V	32	Interest Expense-Fairfax		Lansing Healthcare Properties	100.00%	57,542	57,542	7
8	V	32	Interest Expense-Cole Taylor		Lansing Healthcare Properties	100.00%	164,753	164,753	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 337,260			$ 309,151	$ * (28,109)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		01	Dietary	$	Care Centers, Inc.	100.00%	$ 25	$ 25	15
16	V		05	Utilities		Care Centers, Inc.	100.00%	750	750	16
17	V		06	Maintenance		Care Centers, Inc.	100.00%	783	783	17
18	V		10	Nursing	15	Care Centers, Inc.	100.00%	114	99	18
19	V		11	Activities		Care Centers, Inc.	100.00%	14	14	19
20	V		19	Professional Fees	135,813	Care Centers, Inc.	100.00%	5,014	(130,799)	20
21	V		20	Dues and Subscriptions	7,665	Care Centers, Inc.	100.00%	575	(7,090)	21
22	V		21	Office & Clerical		Care Centers, Inc.	100.00%	8,341	8,341	22
23	V		24	Travel and Seminar		Care Centers, Inc.	100.00%	361	361	23
24	V		26	Insurance		Care Centers, Inc.	100.00%	620	620	24
25	V		30	Depreciation		Care Centers, Inc.	100.00%	3,994	3,994	25
26	V		32	Interest		Care Centers, Inc.	100.00%	7,861	7,861	26
27	V		33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,114	1,114	27
28	V		34	Rent - Building		Care Centers, Inc.	100.00%	1,844	1,844	28
29	V		35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	872	872	29
30	V		25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V		02	Food	44	Care Centers, Inc.	100.00%		(44)	31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 143,537			$ 32,282	$ * (111,255)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 26,894	Care Centers, Inc.	100.00%	$ 27,166	$ 272	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	3,412	3,412	16
17	V	10	Nursing Salary	610	Care Centers, Inc.	100.00%	615	5	17
18	V	10a	Rehab Salary	13	Care Centers, Inc.	100.00%	13		18
19	V	11	Activity Salary	220	Care Centers, Inc.	100.00%	220		19
20	V	12	Social Service Salary	2,558	Care Centers, Inc.	100.00%	2,559	1	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	436	436	21
22	V	17	Administration Salary	71,658	Care Centers, Inc.	100.00%	71,705	47	22
23	V	21	Office Salary	12,414	Care Centers, Inc.	100.00%	12,414		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	10,423	10,423	24
25	V	22	Employee Benefits	17,155	Care Centers, Inc.	100.00%		(17,155)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 131,522			$ 128,963	$ * (2,559)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 3,066	Care Centers, Inc.	100.00%	$ 1,637	$ (1,429)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%	470	470	16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	1,721	1,721	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	475	475	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	5,435	5,435	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	254	254	20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	76	76	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	701	701	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	5,468	5,468	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	54,248	54,248	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	7,378	7,378	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,066			$ 77,863	$ * 74,797	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 2,753	Care Centers, Inc. - Health Systems Division	100.00%	$ 384	$ (2,369)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,285	1,285	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	4	4	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	69	69	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	23	23	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	6	6	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	148	148	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	190	190	22
23	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	2	2	23
24	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	37	37	24
25	V	39	Ancillary Enteral Supplies	2,989	Care Centers, Inc. - Health Systems Division	100.00%	1,395	(1,594)	25
26	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	744	744	26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	97	97	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,742			$ 4,384	$ * (1,358)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 51,172	$ 51,172	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	51,387	CCS EMPLOYEE BENEFIT GROUP	100.00%		(51,387)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 51,387			$ 51,172	$ * (216)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 6,401	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 5,558	$ (842)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	19,926	XCEL MEDICAL SUPPLY, LLC	100.00%	17,304	(2,623)	17
18	V	04	LAUNDRY	91	XCEL MEDICAL SUPPLY, LLC	100.00%	79	(12)	18
19	V	06	REPAIRS & MAINTENANCE	655	XCEL MEDICAL SUPPLY, LLC	100.00%	569	(86)	19
20	V	10	NURSING	13,421	XCEL MEDICAL SUPPLY, LLC	100.00%	11,654	(1,767)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	1,582	XCEL MEDICAL SUPPLY, LLC	100.00%	1,374	(208)	24
25	V	39	ANCILLARY	14,485	XCEL MEDICAL SUPPLY, LLC	100.00%	12,578	(1,907)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 56,561			$ 49,116	$ * (7,445)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.19%	See Attached	0.61	1.11%	Mgt Fee	$ 48,000	17-3	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.26	0.65%	Salary Alloc	205	22-7	2
3	Norman Goldberg	Owner	Administrative	4.76%	See Attached	1.00	1.89%	Salary Alloc	1,956	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 50,161		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,764,895	42	$ 1,527	$	28,632	$ 25	1
2	05	Utilities	Patient Days	1,764,895	42	46,229		28,632	750	2
3	06	Maintenance	Patient Days	1,764,895	42	48,251		28,632	783	3
4	10	Nursing	Patient Days	1,764,895	42	7,018		28,632	114	4
5	11	Activities	Patient Days	1,764,895	42	838		28,632	14	5
6	19	Professional Fees	Patient Days	1,764,895	42	309,074		28,632	5,014	6
7	20	Dues and Subscriptions	Patient Days	1,764,895	42	35,428		28,632	575	7
8	21	Office & Clerical	Patient Days	1,764,895	42	523,091		28,632	8,341	8
9	24	Travel and Seminar	Patient Days	1,764,895	42	22,233		28,632	361	9
10	26	Insurance	Patient Days	1,764,895	42	38,230		28,632	620	10
11	30	Depreciation	Patient Days	1,764,895	42	246,194		28,632	3,994	11
12	32	Interest	Patient Days	1,764,895	42	484,531		28,632	7,861	12
13	33	Real Estate Taxes	Patient Days	1,764,895	42	68,681		28,632	1,114	13
14	34	Rent - Building	Patient Days	1,764,895	42	113,677		28,632	1,844	14
15	35	Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		28,632	872	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,780	$		$ 32,282	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			213,393	213,393		27,166	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			26,918			3,412	2
3	10	Nursing Salary	Direct Cost			976,718	976,718		615	3
4	10a	Rehab Salary	Direct Cost			103,898	103,898		13	4
5	11	Activity Salary	Direct Cost			10,902	10,902		220	5
6	12	Social Service Salary	Direct Cost			306,863	306,863		2,559	6
7	15	Emp. Ben. - Healthcare	Direct Cost			174,348			436	7
8	17	Administration Salary	Direct Cost			1,191,200	1,191,200		71,705	8
9	21	Office Salary	Direct Cost			698,886	698,886		12,414	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			238,998			10,423	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,942,124	$ 3,501,860		$ 128,963	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	28,632	1,637	1
2	03	Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	28,632	470	2
3	06	Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	28,632	1,721	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		28,632	475	4
5	10	Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	28,632	5,435	5
6	10a	Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	28,632	254	6
7	12	Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	28,632	76	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		28,632	701	8
9	17	Administration Salary	Patient Days	1,764,895	42	337,043	337,043	28,632	5,468	9
10	21	Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	28,632	54,248	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		28,632	7,378	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,799,547	$ 4,272,235		$ 77,863	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,073,579		138,556		5,743	384	1
2	02	Food	Billable Income	2,073,579		852,614		5,743	1,285	2
3	06	Maintenance	Billable Income	2,073,579		1,311		5,743	4	3
4	17	Administration	Billable Income	2,073,579		25,000		5,743	69	4
5	19	Professional Fees	Billable Income	2,073,579		8,170		5,743	23	5
6	20	Dues & Subscriptions	Billable Income	2,073,579		2,312		5,743	6	6
7	21	Office & Clerical	Billable Income	2,073,579		53,285		5,743	148	7
8	24	Travel & Seminar	Billable Income	2,073,579		68,680		5,743	190	8
9	32	Interest Expense	Billable Income	2,073,579		571		5,743	2	9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579		13,336		5,743	37	10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		5,743	1,395	11
12	01	Dietary - Salary	Billable Income	2,073,579		268,554	268,554	5,743	744	12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		5,743	97	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,582,287	$ 268,554		$ 4,384	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 51,172	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 51,172	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 5,558	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						17,304	3
4	04	LAUNDRY	Direct Allocation						79	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						569	5
6	10	NURSING	Direct Allocation						11,654	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						1,374	10
11	39	ANCILLARY	Direct Allocation						12,578	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 49,116	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X				$	$ 328,000			$ 21,962	1
2	Cole Taylor		X	Mortgage	$22,010.00	09/01/95	2,620,000	2,291,435			164,753	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Fairfax HC Properties	X		Working Capital				575,000			57,542	6
7	Alloc. Care Centers, Inc.										7,861	7
8	See Supplemental Schedule										2	8
9	TOTAL Facility Related				$22,010.00		$ 2,620,000	$ 3,194,435			$ 252,119	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income										(73,143)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (73,143)	14
15	TOTALS (line 9+line14)						$ 2,620,000	$ 3,194,435			$ 178,976	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0.00 Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. - Care Centers, Inc. -						$	$			$	8
9	Health Systems										2	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	140,280	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	132,645	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,635)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	135,727	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	10,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	138,592	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	107,758	8
	1999	126,918	9
	2000	128,577	10
	2001	133,605	11
	2002	129,274	12

2003 Tax Accrual - $129,274*1.05= $135,737

Allocation from Care Centers - $1,114.22

RE Tax Assisted Living Parcel - $2,257 (Adjusted out pg 5A)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-30-305-035-0000	Long Term Care Property	$ 129,273.80	$ 127,016.80
2.	See Attached	Home Office Allocation	$ 68,681.49	$ 68,681.49
3.	30-30-304-018-0000	Non-Care Property	$ 2,257.35	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 200,212.64	$ 195,698.29

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,244 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Start up costs for Assisted Living Facility detailed on Page 17, line 23.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 40,639
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 7,803
4. Dates Incurred: _____

Nature of Costs: Closing Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 84,986	1
2	2201 Main LLC alloc			8,245	2
3	TOTALS			$ 93,231	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	1,222	1,222	10,101	9
10	Various			1996	82,791		20	4,140	4,140	31,998	10
11	Various			1997	44,854		20	2,245	2,245	14,617	11
12	Various			1998	47,497		20	2,478	(2,478)	14,521	12
13	Various			1999	39,389		20	1,972	1,972	9,301	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,932,035	76,346		146,602	70,256	628,663	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		31,198	1,023		1,023		1,111	68
69	Financial Statement Depreciation			15,120			(15,120)		69
70	TOTAL (lines 4 thru 69)		$ 3,202,195	$ 92,489		$ 159,682	$ 62,237	$ 710,312	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,202,195	$ 92,489		$ 159,682	$ 67,193	$ 710,312	1
2	Garage Doors	2000	700		20	35	35	134	2
3	Garage Doors	2000	700		20	35	35	134	3
4	Hvac Repair	2000	1,753		20	88	88	314	4
5	Hvac Repair	2000	937		20	47	47	168	5
6	Door	2000	860		20	43	43	151	6
7	Wire R & M	2000	780		20	39	39	137	7
8	Hvac Repair	2000	1,753		20	88	88	300	8
9	Hvac Repair	2000	3,770		20	189	189	645	9
10	Wiring	2000	1,300		20	65	65	211	10
11	Doors	2000	987		20	49	49	156	11
12	Plumbing	2000	455		20	23	23	69	12
13	Repairs Walk In Free	2001	595		20	30	30	83	13
14	Hvac	2001	635		20	32	32	83	14
15	Compressor	2001	2,292		20	115	115	287	15
16	Partial Replace-Roof	2001	1,950		20	98	98	244	16
17	Metal Chimney Flash	2001	550		20	28	28	67	17
18	Repair Heating Syste	2001	1,344		20	67	67	156	18
19	60 Gal Paint	2001	779		20	39	39	85	19
20	Cctv System	2001	5,325		20	266	266	799	20
21	Switch & Piping Mate	2001	1,376		20	69	69	201	21
22	Bearing Motor & Asse	2001	892		20	45	45	130	22
23	Replace Air Filters	2001	1,021		20	51	51	145	23
24	A/C Tune Up	2001	1,959		20	98	98	261	24
25	Grease Trap In Kitch	2001	685		20	34	34	92	25
26	Repair Hvac	2001	1,218		20	61	61	137	26
27	Paint	2002	1,067		20	107	107	213	27
28	Corner Guards	2002	876		20	88	88	175	28
29	Paint	2002	916		20	92	92	183	29
30	Valve Replacement	2002	1,130		20	113	113	188	30
31	Install Exit & Emerg. Lights	2002	860		20	172	172	272	31
32	Paint	2002	818		20	82	82	116	32
33	Decorating-Paint	2002	543		20	54	54	72	33
34	TOTAL (lines 1 thru 33)		$ 3,243,021	$ 92,489		$ 162,124	$ 69,635	$ 716,720	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,243,021	$ 92,489		$ 162,124	$ 69,635	$ 716,720	1
2	Paint	2002	2,143		20	107	107	107	2
3	Boiler Repair	2003	4,263		20	355	355	355	3
4	Heating Equip.	2003	501		20	23	23	23	4
5	Boiler Equip.	2003	500		20	23	23	23	5
6	Hot Water Heating Coils	2003	2,464		20	110	110	110	6
7	Fixed Broken Piping	2003	835		20	32	32	32	7
8	Air Condition Start Up	2003	1,919		20	56	56	56	8
9	Exhaust System For Oxygen	2003	2,150		20	90	90	90	9
10	Generator Maint.	2003	1,445		20	30	30	30	10
11	Awning Roto Gear Operator	2003	1,916		20	80	80	80	11
12	Garden Work	2003	998		20	42	42	42	12
13	Exterior Repairs	2003	1,541		20	51	51	51	13
14	Faucet And Back Splash	2003	934		20	16	16	16	14
15	Water Heater Repair	2003	1,112		20	9	9	9	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,265,742	$ 92,489		$ 163,148	$ 70,659	$ 717,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1995	1962	$ 2,932,035	$ 76,346		$ 146,602	$ 70,256	$ 628,663	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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54									54
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,932,035	$ 76,346		$ 146,602	$ 70,256	$ 628,663	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main, LLC		2002		$ 11,366	$ 264	35	$ 264	$	$ 308	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	2201 Main, LLC			2002	10,524	526	35	526		570	10
11	2201 Main, LLC			2003	9,308	233	35	233		233	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 31,198	$ 1,023		$ 1,023	$	$ 1,111	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 193,278	$ 18,768	$ 20,336	$ 1,568	10	$ 128,839	71
72	Current Year Purchases	28,909	10,615	8,642	(1,973)	10	8,642	72
73	Fully Depreciated Assets	173,235				10	173,235	73
74								74
75	TOTALS	$ 395,422	$ 29,383	$ 28,978	$ (405)		$ 310,716	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	1997	$ 47,208	$	$	$	5	$ 35,408	76
77	Care Center Allocation	AUTO		11,819	1,276	1,276		5	9,300	77
78										78
79										79
80	TOTALS			$ 59,027	$ 1,276	$ 1,276	$		$ 44,708	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,813,422	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,148	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 193,402	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 70,254	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,073,168	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Care Center Allocation				1,844			5
6								6
7	TOTAL				$ 1,844 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 6,121 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 100,520	$		$ 100,520	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			7,941			7,941	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			103,413			103,413	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				78,810		78,810	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						39,988		39,988	13
14	TOTAL			$		$ 211,874	$ 118,798		$ 330,672	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 187,163	$ 221,653	1
2	Cash-Patient Deposits	20,777	20,777	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	536,611	673,351	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,913	103,913	6
7	Other Prepaid Expenses	5,097	5,097	7
8	Accounts Receivable (owners or related parties)		10,000	8
9	Other(specify): See Attached Schedule	1,350,906	1,350,906	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,204,467	$ 2,385,697	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		115,041	13
14	Buildings, at Historical Cost		2,977,499	14
15	Leasehold Improvements, at Historical Cost	265,017	265,017	15
16	Equipment, at Historical Cost	284,112	454,085	16
17	Accumulated Depreciation (book methods)	(295,938)	(1,094,574)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		104,720	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 253,191	$ 2,821,788	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,457,658	$ 5,207,485	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 336,457	$ 473,197	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,549	18,549	28
29	Short-Term Notes Payable	328,000	328,000	29
30	Accrued Salaries Payable	155,704	155,704	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,864	6,864	31
32	Accrued Real Estate Taxes(Sch.IX-B)	135,727	135,727	32
33	Accrued Interest Payable		59,842	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(6,741)	(6,741)	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	233,445	3,234	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,208,005	$ 1,174,376	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		575,000	39
40	Mortgage Payable		2,291,435	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,866,435	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,208,005	$ 4,040,811	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,249,653	$ 1,166,674	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,457,658	$ 5,207,485	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 871,860	1
2	Restatements (describe):		2
3	**Adjusting entries - Expense 12/31/02**	(900)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 870,960	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	378,693	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 378,693	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,249,653	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,155,115	1
2	Discounts and Allowances for all Levels	(1,124,562)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,030,553	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,032,338	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,032,338	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,200	16
17	Sale of Drugs	83,947	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,507	19
20	Radiology and X-Ray	4,730	20
21	Other Medical Services	30,392	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 137,776	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73,143	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 73,143	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,273,810	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	688,553	31
32	Health Care	1,504,630	32
33	General Administration	793,307	33
	B. Capital Expense		
34	Ownership	531,965	34
	C. Ancillary Expense		
35	Special Cost Centers	330,672	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,895,117	40
41	**Income before Income Taxes (line 30 minus line 40)****	378,693	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 378,693	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,217	$ 66,666	$ 30.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,923	6,560	142,698	21.75	3
4	Licensed Practical Nurses	21,876	24,695	508,023	20.57	4
5	Nurse Aides & Orderlies	46,622	51,319	466,755	9.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,538	7,476	112,386	15.03	8
9	Activity Director	1,989	2,091	27,834	13.31	9
10	Activity Assistants	5,260	5,576	43,050	7.72	10
11	Social Service Workers	3,645	3,911	62,471	15.97	11
12	Dietician					12
13	Food Service Supervisor	1,938	2,130	32,256	15.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,731	16,532	143,909	8.70	15
16	Dishwashers					16
17	Maintenance Workers	1,982	2,275	35,471	15.59	17
18	Housekeepers	9,813	10,839	87,484	8.07	18
19	Laundry	6,163	6,870	67,757	9.86	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,779	6,484	57,300	8.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,880	2,079	21,921	10.54	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	136,147	151,054	$ 1,875,981 *	$ 12.42	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	237	$ 9,589	01-03	35
36	Medical Director	Monthly	7,375	09-03	36
37	Medical Records Consultant	Monthly	3,784	10-03	37
38	Nurse Consultant	Monthly	100	10-03	38
39	Pharmacist Consultant	Monthly	1,430	10-03	39
40	Physical Therapy Consultant	22	1,161	10a-03	40
41	Occupational Therapy Consultant	20	1,085	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	771	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	CCI Salary		3,300	Various	48
49	TOTAL (lines 35 - 48)	295	$ 28,595		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Eric Rothner - Management Fee	$ 48,000
Administrative Payroll	71,658
TOTAL (agree to Schedule V, line 17, col. 3)	$ 119,658
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers Inc.	Home Office	$ 70,560
Care Centers Inc.	Ancillary Admin Services	10,080
Personnel Planners	Unemployment Tax Consult	885
Care Centers Inc.	Bookkeeping Service	17,136
Care Centers Inc.	Accounting	15,000
FR&R	Accounting	18,000
Care Centers Inc.	Legal	9,748
Keane & Keane	Legal	6,500
Levenfeld Pearlstein	Legal	6,570
Care Centers Inc.	Other Professional	7,847
TEG	Utility Management Services	525
See Supplemetal Schedule		37,738
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 200,589

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,539
Unemployment Compensation Insurance	22,065
FICA Taxes	141,016
Employee Health Insurance	58,399
Employee Meals	4,526
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	388
Misc Employee Welfare	3,755
Holiday Expense	1,756
Employee Physical	522
TOTAL (agree to Schedule V, line 22, col.8)	$ 239,965

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	907
Health Care Worker Background Check	
(Indicate # of checks performed 52)	518
Advertising & Promotion	4,719
Dues & Subscriptions	3,243
Licenses & Fees	3,321
Alloc. Care Centers, Inc.	575
IL Council on LTC	(1,068)
See Supplemental Schedule	6
Less: Public Relations Expense	( )
Non-allowable advertising	(4,719)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,502

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	525
Alloc. Care Centers, Inc.	361
Educational Expense	15
See Supplemental Schedule	190
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,091

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Tri-State Nsg & Rehab Ctr # 0041186 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nsg & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $4,021.92**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **744** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **45,990**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,526** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.